

Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155740	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 03/28/2012
NAME OF PROVIDER OR SUPPLIER TIMBERCREST CHURCH OF BRETHREN		STREET ADDRESS, CITY, STATE, ZIP CODE 2201 EAST ST NORTH MANCHESTER, IN 46962		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R 000	<p>INITIAL COMMENTS</p> <p>This visit was for the Investigation of Complaint IN00105655.</p> <p>Complaint IN00105655 - Substantiated. No deficiencies related to the allegation were cited.</p> <p>Survey date: March 28, 2011</p> <p>Facility number: 000448 Provider number: 155740 AIM number: 100275140</p> <p>Survey team: DeAnn Mankell, R.N., TC</p> <p>Census bed type: SNF/NF: 59 Residential: 144 Total: 203</p> <p>Census payor type: Medicare: 2 Medicaid: 30 Other: 171 Total: 203</p> <p>Sample (Residential): 3</p> <p>Timbercrest Church of the Brethren was found to be in compliance with 410 IAC 16.2 in regard to the Investigation of Complaint IN00105655.</p> <p>Quality review 3/29/12 by Suzanne Williams, RN</p>	R 000		

Indiana State Department of Health

TITLE

(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

STATE FORM

6899

87KF11

If continuation sheet 1 of 1